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ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complainant Investigation #68160.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility identified a census of 50 residents. Based on observation and interview, the facility failed to label the towel bars in semi-private rooms on 2 of 3 halls. Findings included: - On 1/7/14 at 1:15 P.M. the environmental tour revealed semi-private rooms on the 200 and 300 halls had towel bars that were not labeled for individual resident use. Throughout the environmental tour on 1/7/14 maintenance staff X acknowledged the towel bars were not labeled. The facility failed to individualize towel bars in semi-private rooms.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 279	Continued From page 1 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 50 residents and the sample included 19 residents. Based on record review, observation and interview, the facility failed to provide an individualized plan of care for 3 (#17, 23 and 24) of the 19 residents sampled. Findings included: - Resident #24's quarterly (MDS) Minimum Data Set dated 12-4-2013 documented the Brief Interview for Mental Status score of 15, which indicated intact cognition. The care plan dated 10-13-2013 for Activities of Daily Living (ADLs) documented the resident required the assist of one staff with his/her ADLs. The resident preferred a whirlpool bath. Staff were to refer to the bath schedule and inform the resident of bath days. The ADL flow sheet dated December 2013	F 279		

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revealed the resident received a shower or whirlpool bath 3 times per week.

Observation on 1-2-2014 at 3:13 P.M. revealed the resident in his/her room sitting in his/her recliner, awake and alert. The resident stated I am doing ok.

Interview on 12-30-13 at 1:39 P.M. with the resident revealed he/she would like a bath everyday.

Interview on 1-7-2014 at 3:06 P.M. with direct care staff O revealed the resident liked to take whirlpool baths and he/she took them twice a week.

Interview on 1-8-14 at 12:47 P.M. with licensed staff H acknowledged the resident's care plan did not include bathing preference or frequency. The admission check list for nursing assistant dated 9-5-12 revealed the resident would like a bath when getting up and twice a week.

Interview on 1-8-2014 at 3:06 P.M. with administrative nursing staff D revealed the care plan did not include the frequency of bathing. The admission care plan dated 9-6-2012 documented the resident would like to bathe in the AM every other day.

The facility provided 2-28-07 care plans, assessments and MDS document revealed all resident MDS and care plans shall be completed within 14 days of admission, involving the resident, family and interdisciplinary staff. These shall be done again quarterly and annually thereafter. If a significant change is noted, the MDS and care plan shall be revised at that time as well.

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F 279	Continued From page 3 The facility failed to provide an individualized plan of care regarding frequency of bathing for this resident. - Resident #23's medical diagnosis listed in the electronic chart dated 5-1-2013 displayed dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The significant change (MDS) Minimum Data Set dated 11-29-2013 documented the Brief Interview for Mental Status score of 15 which indicated intact cognition. The resident needed extensive assistance with one person physical assist with personal hygiene. The care plan dated 9-4-2013 for self care deficit documented the resident required the assist of one staff for bathing. He/she could pick a shower or bath. He/she wanted his/her current schedule of one time a week. When he/she wanted additional showers he/she would ask. The care plan lacked interventions for shaving and nail care. The (ADL) Activities of Daily Living flow sheet dated December 2013 lacked documentation of nail care and shaving. The ADL sheet dated November 2013 lacked documentation of shaving the resident and nail care except for 11-1-2013. Observation on 1-6-2014 at 12:54 P.M. revealed the resident had facial hair present on his/her chin and jagged nails. Observation on 1-7-14 at 9:53 A.M. revealed the	F 279		

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resident had facial hair on his/her chin and jagged nails on both hands.

Interview on 1-7-2014 at 3:06 P.M. with direct care staff O revealed staff shaved the residents on bath days or when it was needed, in the mornings. Staff assisted this resident to shave.

Interview on 1-8-2014 at 12:47 P.M. with licensed staff H revealed the (CNAs) Certified Nursing Assistants shaved the residents on bath days twice a week or upon resident request. Nail care was completed by the CNAs on bath days. If the resident was a diabetic the nurse was responsible for completing nail care. Resident #23 required assistance with personal hygiene, bathing, and set up help for him/her in the morning. I do not know if he/she was able to shave himself/herself.

Interview on 1-8-2014 at 3:06 P.M. with administrative nursing staff D revealed the CNAs were responsible for shaving the residents. The residents were shaved on bath days and on the resident's preference. Resident #23 did not like to take baths. Administrative nursing staff D stated I do not think shaving was in the care plan. That often gets overlooked with women.

The facility provided 2-28-07 care plans, assessments and MDS document revealed all resident MDS and care plans shall be completed within 14 days of admission, involving the resident, family and interdisciplinary staff. These shall be done again quarterly and annually thereafter. If a significant change is noted, the MDS and care plan shall be revised at that time as well.

The facility failed to provide an individualized plan of care for shaving and nail care for this resident.

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F 279	Continued From page 5 - The hospice progress notes displayed resident #17 was admitted to hospice on 9-24-13. The significant change (MDS) Minimum Data Set dated 12-30-2013 documented the Brief Interview for Mental Status score of 15 which indicated cognition intact. The resident required total assistance of one person with personal hygiene. The resident required total assistance of two people with bathing. The (CAA) Care Area Assessment for Activities of Daily Living (ADL) dated 12-31-2013 documented the resident had a self care deficit. The resident required two (Certified Nursing Assistants' assistance due to his/her being weak and feeling tired. He/she said his/her arms were heavy and he/she just cannot do things like he/she used to. The care plan dated 12-31-13 documented the resident had a self care deficit and required help to complete his/her ADLs. Hospice bathes the resident one time per week. The CNA was to assist him/her to bathe. The care plan lacked additional interventions for hospice services including what supplies and medications they provided along with the disciplines who saw the resident and the frequency. The ADL flow sheet dated December 2013, November 2013, and October 2013 lacked documentation staff shaved the resident. Observation on 1-6-2014 at 1:01 P.M. revealed facial hair on resident's chin.	F 279		

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F 279	Continued From page 6 Observation on 1-7-2014 at 10:14 A.M. revealed facial hair on the resident's chin. Interview on 1-7-2014 at 3:06 P.M. with direct care staff O revealed staff completed personal hygiene for this resident. He/she was not able to shave himself/herself, staff shaved him/her. Staff shaved the residents on bath days or when it is needed, staff shave them in the mornings. The resident was on hospice, and hospice would come in the facility to give him/her showers. Bathing was a shared responsibility between the facility and hospice. Interview on 1-8-2014 at 12:47 P.M. with licensed nursing staff H acknowledged the resident did not have a care plan for shaving. The CNAs shave him/her on bath days and I know hospice did also. The resident went on hospice on 9-24-2013. Licensed nurse H acknowledged the resident did not have a care plan for hospice services. Hospice staff came in and bathed him/her twice a week and the facility staff also bathed him/her. Hospice provided oxygen, the bed, air mattress and some supplements. If there were medication changes hospice would contact the doctor. Hospice staff provided care to the resident 2 to 3 times per week. Interview on 1-8-2014 at 4:29 P.M. with administrative nursing staff D stated I would have expected staff to shave him/her or provide encouragement. I would expect there to be a hospice care plan in his/her chart. The facility provided 2-28-07 care plans, assessments and MDS document revealed all resident MDS and care plans shall be completed within 14 days of admission, involving the resident, family and interdisciplinary staff. These	F 279		

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F 279	Continued From page 7 shall be done again quarterly and annually thereafter. If a significant change is noted, the MDS and care plan shall be revised at that time as well. The facility failed to develop a comprehensive individualized plan of care regarding shaving and hospice services for this resident.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: The facility identified a census of 50 residents. The sample included 19 residents of which three were reviewed for Activities of Daily Living (ADL). Based on observation, record review and interview, the facility failed to provide shaving and/or nail care for two (#17 and 23) residents of the sample. Findings included: - Resident #23's medical diagnosis listed in the electronic chart dated 5-1-2013 included dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The significant change (MDS) Minimum Data Set dated 11-29-2013 documented the Brief Interview for Mental Status score of 15 which indicated cognition intact. The resident needed extensive assistance of one person for personal hygiene.	F 312		

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F 312	Continued From page 8 The care plan dated 9-4-2013 for self care deficit documented the resident required the assist of one staff for bathing. The resident could pick a shower or bath. The resident wanted his/her current schedule of one time a week. When he/she wanted additional showers he/she would ask. The care plan lacked interventions for shaving and nail care. The (ADL) Activities of Daily Living flow sheet dated December 2013 lacked documentation of nail care and shaving. The ADL sheet dated November 2013 lacked documentation for shaving the resident and nail care except of 11-1-2013. Observation on 1-6-2014 at 12:54 P.M. revealed the resident had facial hair present on his/her chin and jagged nails. Observation on 1-7-14 at 9:53 A.M. revealed the resident with facial hair on his/her chin and jagged nails on both hands. Interview on 1-7-2014 at 3:06 P.M. direct care staff O stated staff shaved the residents on bath days or when needed, staff shave the residents in the mornings. Staff assisted this resident to shave. Interview on 1-8-2014 at 12:47 P.M. licensed staff H stated the (CNAs) Certified Nursing Assistant shaved the residents on bath days twice a week or upon the resident request. Nail care was completed by the CNAs on bath days. If the resident was a diabetic the nurse was responsible to complete nail care. Resident #23 required assistance with personal hygiene, bathing, and	F 312		

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set up help in the morning. I do not know if he/she was able to shave himself/herself.

Interview on 1-8-2014 at 3:06 P.M. administrative nursing staff D stated the CNAs were responsible for shaving the residents. The resident's were shaved on bath days and based on the resident's preference. Resident #23 did not like to take baths. Administrative nursing staff D stated I do not think shaving was in the care plan. That often gets overlooked with women.

The facility failed to provide a policy on shaving and nail care.

The facility failed to shave and provide nail care for this dependent resident.

- The significant change (MDS) Minimum Data Set dated 12-30-2013 for resident #17 documented a (BIMS) Brief Interview for Mental Status score of 15 which indicated intact cognition. The resident required total assistance of one person for personal hygiene. The resident required total assistance of two people for bathing.

The (CAA) Care Area Assessment for Activities of Daily Living (ADL) dated 12-31-2013 documented the resident had a self care deficit. The resident required two (CNA) Certified Nursing Assistant assistance due to his/her being weak and feeling tired. He/she said his/her arms were heavy and he/she just cannot do things like he/she used to.

The care plan dated 12-31-13 documented the resident had a self care deficit and required help to complete his/her ADLs and staff assisted

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F 312	Continued From page 10 him/her to bathe. The ADL flow sheet for December 2013, November 2013, and October 2013 lacked documentation staff shaved the resident. Observation on 1-6-2014 at 1:01 P.M. revealed facial hair on the resident's chin. Observation on 1-7-2014 at 10:14 A.M. revealed facial hair on the resident's chin. Interview on 1-7-2014 at 3:06 P.M. direct care staff O stated staff completed personal hygiene for the resident. He/she was not able to shave himself/herself.. Staff shaved the residents on bath days or when it was needed in the mornings. Interview on 1-8-2014 at 12:47 P.M. licensed nursing staff H acknowledged the resident did not have a care plan for shaving. The CNAs shave him/her on bath days. Interview on 1-8-2014 at 4:29 P.M. with administrative nursing staff D stated I would have expected staff to shave him/her or provide encouragement. The facility failed to provide a policy on shaving. The facility failed to provide personal hygiene care for this dependent resident.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This Requirement is not met as evidenced by:
The facility had a census of 50 residents. The sample included 19 residents. Based upon observation, record review and interviews the facility failed to reposition 2 (#35, #18) of 2 residents at risk for pressure sore development.

Findings included:

- Resident #35's quarterly Minimum Data Set (MDS) 3.0 dated 10/10/13 identified the resident had severely impaired cognition, were totally dependent upon staff for bed mobility, locomotion on/off the unit, dressing, eating, personal hygiene and toilet use. The MDS coded the resident was at risk for the development of pressure ulcers and was not on a turning/repositioning program.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 7/17/13 documented the resident was totally dependent upon staff for activities of daily living.

The resident's Pressure Ulcer CAA dated 7/17/13 documented the resident had the potential for alteration in his/her skin integrity. The resident was incontinent of bowel and bladder.

The resident's care plan dated 10/7/13 included staff repositioned the resident every 1 to 2 hours during the day and at night during rounds.

On 1/2/14 the resident sat in the television room in a recliner at 9:30 AM, 9:45 A.M., 10:00 A.M.,

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10:15 A.M., 10:30 A.M., 10:45 A.M., 11:00 A.M., 11:15 A.M., 11:30 A.M. and 11:45 A.M. (duration of 2 hours and 15 minutes) with no change in position.

On 1/6/14 the resident sat in the television room in a recliner at 9:28 A.M., 9:39 A.M. 9:50 A.M., 10:00 A.M., 10:10 A.M., 10:15 A.M., 10:30 A.M., 10:45 A.M., 11:00 A.M., 11:15 A.M., 11:30 A.M. and 11:45 A.M. (duration of 2 hours and 17 minutes) with no change in position.

On 1/6/14 the resident laid in bed on his/her back at 1:00 P.M., 1:15 P.M., 1:30 P.M., 1:45 P.M., 2:00 P.M., 2:15 P.M., 2:30 P.M., 2:45 P.M., 3:15 P.M., 3:30 P.M., 3:45 P.M. (a duration of 2 hours and 45 minutes) with no change in position.

On 1/7/14 at 4:50 P.M. direct care staff Q stated staff repositioned the resident at least every 2 hours.

On 1/8/14 at 2:23 P.M. licensed nurse J stated staff repositioned the resident at least every 2 hours.

On 1/8/14 at approximately 3:00 P.M. administrative nursing staff D stated staff determined the need of the resident's repositioning every hour or two based on the resident's abilities that day.

The facility failed to reposition this severely impaired dependent resident at risk for the development of pressure ulcers every 1 to 2 hours as planned.

- Resident #18's annual Minimum Data Set (MDS) dated 10/15/13 identified the resident had

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severely impaired cognition, no behaviors, was totally dependent upon staff for bed mobility, transfers, locomotion on/off the unit, dressing, eating, toilet use, personal hygiene and the resident did not walk in the room/corridor. The MDS coded the resident used a wheelchair, was always incontinent of urine, was at risk for the development of pressure ulcers and was not on a turning/repositioning program.

The resident's care plan dated 10/22/13 included the resident could not turn on his/her own, and was totally dependent upon staff for repositioning. The resident's bed had a low air loss mattress, staff turned/repositioned the resident every 1 to 2 hours and as needed, and used pillows as needed for support.

On 1/6/14 at 1:00 P.M. the resident laid in bed. Observation revealed a pillow behind the resident's right back but the resident was positioned more on his/her back than side. The resident continued in that position at 1:15 P.M. 1:30 P.M., 1:45 P.M., 2:00 P.M., 2:15 P.M., 2:30 P.M., 2:45 P.M., 3:15 P.M., 3:30 P.M., 3:45 P.M. (a duration of 2 hours and 45 minutes) with no change in position.

On 1/8/14 the resident sat in the television room in a recliner at 9:19 A.M., 9:30 A.M., 9:45 A.M., 9:50 A.M., 10:00 A.M., 10:10 A.M., 10:20 A.M., 10:30 A.M., 10:40 A.M., 10:45 A.M., 11:00 A.M., 11:15 A.M., 11:30 A.M., 11:45 A.M. (a duration of 2 hours and 25 minutes) with no change in position.

On 1/7/14 at 3:37 P;.M. direct care staff R stated staff repositioned the resident at least every 2 hours.

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F 314	Continued From page 14 On 1/8/14 at 2:20 PM licensed nurse J stated the resident was totally dependent upon staff for repositioning/turning. Licensed nurse J stated the resident's bed had a low air low mattress; therefore staff may not reposition the resident every 2 hours. On 1/8/14 at 3:16 P.M. administrative nursing staff D stated staff repositioned/turned the resident at least every 2 hours. The facility failed to reposition this severely impaired dependent resident at risk for the development of pressure ulcers every 1 to 2 hours as planned.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 50 residents. The sample included 16 residents. Based upon observation, record review and interviews the facility failed to toilet a resident as planned for 1 (#13) of 3 sampled residents. Findings included: - Resident #13's Physician Order Sheet for	F 315		

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December 2013 included the resident had diagnosis that included urinary tract infection (infection that can happen anywhere along the urinary tract-UTI).

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 10/7/13 identified the resident scored 14 (cognition intact) on the Brief Interview for Mental Status, and the resident did not have behaviors. The MDS included the resident required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, dressing, toilet use, and personal hygiene, and limited staff assistance with walking in the room/corridor. The MDS coded the resident was frequently incontinent of urine and was not on a scheduled toileting plan and utilized a walker or wheelchair.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/15/13 documented the resident had impaired cognition and was confused at times.

The resident's Activities of Daily Living (ADL) CAA dated 1/15/13 documented the resident required staff assistance to complete his/her ADLs.

The resident's Urinary Incontinence CAA dated 1/15/13 documented the resident was incontinent of bowel and bladder. The resident had some urinary urgency and required assistance of one staff for mobility.

The resident's care plan dated 10/8/13 included the resident had short term memory problems and a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The care plan addressed the resident

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was incontinent of urine and required staff assistance to get to and from the bathroom. The care plan included due to the resident's urinary urgency and incontinence staff prompted and assisted the resident to the toilet upon awakening, mid A.M. (approximately 10 A.M.) before and after the resident ate his/her meals, mid afternoon (approximately 2 P.M. to 2:30 P.M.) and at night.

The resident's Bowel & Bladder Study performed 4/11/13 to 4/13/13 included 2 hour intervals (6-8 A.M., 8-10 A.M.,etcetera). Review of the resident's 3 day voiding diary did not support staff prompted the resident to use the bathroom and/or checked the resident for urinary incontinence during the 2 hour interval. For example staff did not document in the two hour interval during the time frame of 4-6 P.M., 6-8 P.M. 8 -10 P.M. on 4/11/13. An handwritten entry on the bottom of the sheet dated 4/11/13 documented continue with the plan. There was no evidence to support how the facility reached the decision to continue with the plan.

Review of the resident's clinical record identified the resident had a history of urinary tract infections.

On 1/6/14 at 8:15 A.M. the resident sat in his/her wheelchair in the dining room. Observation revealed the resident had consumed all of his/her breakfast meal.

On 1/6/14 at 8:25 A.M. the resident propelled himself/herself from the dining room. At 8:35 A.M. the resident sat in the wheelchair in his/her room. At 8:45 A.M. the resident stated staff did not offer to toilet him/her after meals. At 9:00 A.M. the resident sat in the wheelchair in his/her

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room. At 9:30 A.M. the resident stated staff had not offered to toilet him/her (1 hour after the resident finished his/her meal).

On 1/6/14 the resident sat in the recliner in his/her room at 9:45 A.M. Observation revealed the resident appeared asleep. The same observation was observed at 10:00 A.M., 10:15 A.M., 10:30 A.M., 10:45 A.M., 11:00 A.M., and 11:15 A.M. At 11:30 A.M. the resident sat in his/her recliner for 1 hour and 45 minutes without a change in position.

On 1/6/14 at 11:45 A.M. direct care staff T entered the resident's room. Direct care staff T stated the resident asked staff to change his/her incontinent brief. Direct care staff S entered the resident's room and assisted direct care staff T. Direct care staff T and S assisted the resident to stand from the recliner. Direct care staff T stated the resident was incontinent of urine and direct care staff T performed incontinent care. During interview with direct care staff T at that time he/she stated the resident was not on a toileting program. Direct care staff T stated the resident activated his/her call light when he/she needed to use the bathroom.

On 1/7/14 at 4:32 P. M. direct care staff P stated the resident activated his/her call light to alert staff if he/she needed his/her incontinent brief change and/or needed to go to the bathroom. Direct care staff P stated the resident was incontinent of urine at times.

On 1/8/14 at 3:13 P.M. nursing administrative staff D stated the resident was incontinent and he/she was not sure if the resident was on a toileting program. Nursing administrative staff D stated the resident's care plan included if the

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F 315	Continued From page 18 resident was on a toileting program. The facility's undated Incontinency Care/Bowel and Bladder Control Protocol included staff completed a three day bowel and bladder study form on each resident upon admission, annually and significant changes. Nurses then set up a bladder/bowel toilet program for residents with altered mental status or incontinence according to the resident's individual needs. The facility failed to toilet this frequently incontinent resident of urine with a history of UTIs as planned.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 50 residents. The sample was 3 residents. Based on observation, record review, and interview, the facility failed to implement effective interventions for 3 (#3, #16, and #47) residents that resulted in injuries. Findings included: - Resident #3's quarterly Minimum Data Set (MDS) 3.0 dated 12/9/13 identified the resident had moderately impaired cognition, short and	F 323		

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long term memory impairment, and physical behavioral symptoms 1 to 3 days of the 7 day look back period. The MDS identified the resident was totally dependent upon staff for bed mobility and personal hygiene, required extensive staff assistance with transfers, dressing, eating, and toilet use. The MDS identified the resident was not steady, and was only able to stabilize with staff assistance when moving on/off the toilet, surface to surface transfer and when moved from seated to standing position, the activity of walking and turning around and facing the opposite directions while walking did not occur. The MDS identified the resident was frequently incontinent of urine, and had 2 or more non-injury falls since admission or the prior assessment.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 9/11/13 documented the resident needed assistance with all of his/her activities of daily living (ADL's), the resident did not remember to call for staff assistance, and staff frequently checked on the resident.

The resident's ADL Functional/Rehabilitation Potential CAA dated 9/11/13 documented the resident had ADL deficit, advanced dementia, did not make his/her needs known, was incontinent of bowel and bladder, required assistance of 1 to 2 staff, the resident did not walk, and did not follow simple direct questions. The CAA included the resident did not use his/her call light so staff frequently checked on him/her.

The resident's Fall CAA dated 9/11/13 documented the resident was at risk for falls, fell in the last 6 months and had a fall on 9/10/13. The CAA included 2 staff transferred the resident

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to ensure his/her safety, used a wheelchair for all locomotion, the resident did not ambulate and staff propelled him/her to all areas. The resident had a diagnosis of dementia, did not use his/her call light, and staff frequently checked on the resident.

The resident's care plan included the following interventions effective 7/9/13: The resident's was at an increased fall risk because he/she dropped items. Staff picked up the dropped items and ensured the items were within the resident's reach. The resident forgot to use his/her call light, staff checked on him/her frequently when in his/her room. The resident's required 1 or 2 staff assistance with transfer up from his/her recliner. The resident did not ambulate, used wheelchair for all locomotion, and the staff propelled the resident's wheelchair.

A nurse's note dated 9/10/2013 and timed 2:59 P.M. included at 11:55 A.M. the resident attempted to stand up and slid out of his/her wheelchair. Interventions included staff would not leave the resident unattended in the dining room.

A nurse's note dated 9/23/2013 timed 10:46 P.M. documented at 10:05 P.M. staff observed the resident on the floor with his/her head up against the bed rails, the resident stated he/she rolled out of bed and hit his/her head on the bed rails. The resident had a hematoma (collection of blood outside of the blood vessels) on his/her right hand and a skin tear below the knee on his/her left leg. Interventions included removal of the side rails and the placement of a mobility bar.

A nurse's note dated 10/13/2013 and timed 3:19 A.M. documented the resident sat on the floor with his/her legs stretched in front of him/her, the

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resident sat on blankets and a pillow and the resident stated he/she slipped from the side of the bed. Interventions included staff checked on the resident frequently; and checked his/her bedding frequently.

A nurse's note dated 10/18/2013 and timed 3:10 P.M. documented staff observed the resident on the floor at 11:45 P.M.

A nurse's note dated 11/18/2013 and timed 6:34 P.M. documented at 4:30 P.M. a staff stated the resident slid out of his/her wheelchair. The note included the resident sat upright on the pedals of his/her wheelchair. Interventions included staff placed a different cushion in the resident's wheelchair.

A nurse's note dated 11/19/2013 and timed 6:28 P.M. documented the raised area on the resident's left arm continued, and a faded bruise noted in front of the area. Staff was unsure if the above occurred when the resident slipped from the wheelchair on 11/18/13.

A nurse's note dated 11/24/2013 and timed 1:40 A.M. documented the resident's roommate called out, staff entered the room and observed the resident sitting upright on the floor near the center of his/her bed. The resident stated he/she tried to get up to go to the bathroom, but had "fell out of bed." Blankets were observed on floor next to the bed. The interventions included toileting the resident and frequent checks.

A nurse's note dated 11/25/13 and timed 10:28 P.M. documented at 10:00 P.M. staff observed the resident on the floor. The note included the resident slid from his/her wheelchair to the floor. Interventions included staff would know the

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resident's whereabouts at all times, the resident was quite anxious at times and staff frequently checked on the resident. The resident had new tennis shoes with non skid soles when in his/her room. Staff transferred the resident to his/her recliner and did not leave the resident unattended in the wheelchair in his/her room.

A nurse's note dated 1/1/2014 and timed 2:49 A.M. documented the resident laid on a blanket on the floor bedside his/her bed at 1:45 A.M. The note included the resident had a quarter sized abrasion on the upper left side of his/her forehead, and staff performed neurological checks because the resident hit his/her head.

A nurse's note dated 1/1/2014 and timed 4:47 A.M. documented the resident's child came to the facility to check on the resident, the hematoma on the resident's forehead had increased, the resident's child wanted the resident transferred to a local hospital and an ambulance transferred the resident to the hospital.

The resident's discharge orders and instructions/transfer form from the local hospital dated 1/1/14 timed 4:30 P.M. documented the resident's primary diagnosis as an head injury and the resident's secondary diagnosis as vertebral fracture. The form included the resident required assistance with ambulation.

A nurse's note dated 1/1/2014 and timed 10:14 P.M. documented the resident returned to the facility. The resident wore a soft collar, the resident's left eye was swollen shut, the resident's right eye was swollen, and the resident had a bruise on his/her forehead above his/her left eye. The note included the resident's children requested the resident wore a personal body

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alarm (PBA) when in bed.

A nurse's note dated 1/3/2014 and timed 2:52 A.M. documented the resident's PBA sounded, and staff found the resident siting on the side of his/her bed.

The local hospital emergency department history and physical with an encounter date of 1/1/14 documented per emergency medical staff, upon rounds staff found the resident on the floor beside his/her bed. The resident had a hematoma and swelling to and above his/her left eye.

The resident's facial bones CT (computed tomography-type of X-ray) without contrast dated 1/1/14 included the resident had extensive soft tissue edema overlying his/her left front scalp and orbit (eye).

The resident's CT of his/her Cervical Spine dated 1/1/14 included the resident fell, he/she had a large bruise above his/her left eye and a laceration (cut in the skin) of the forehead. The impression of the CT was a corner fracture seen at the C2 anterior inferior vertebral body (broken bone in the neck). Consider cervical spine MRI to evaluate for soft tissue injury.

The resident's CT of the Head without contrast dated 1/1/14 included the resident fell and sustained a massive left frontal scalp hematoma.

A local hospital's patient visit information dated 1/2/14 and timed 4:06 P.M. included the resident was seen for contusion (blood leaked into tissue under the skin) of his/her left hip.

On 1/2/14 at 1:30 P.M. observation revealed the resident laid in bed. Further observation revealed

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a large purple colored hematoma above his/her left forehead with an abrasion in the center of the hematoma, purple colored bruises under the resident's eyes bilaterally, and the left side of the residents's jaw with purple colored bruise.

On 1/6/14 at 8:15 A.M. the resident sat at a dining room table in his/her wheelchair. Observation revealed the hematoma and the bruising on the resident's jaw and underneath his/her eyes still present. Further observation revealed a personal body alarm (PBA) in place and the resident wore a soft C-collar (device used to give stability to the neck).

On 1/6/14 at 1:25 P.M. observation revealed the resident's bed without a positioning bar as planned. The resident's bed had a pressure reducing mattress with built in wings/bolsters.

On 1/6/14 at 3:30 P.M. at 3:30 P.M. observation revealed bilateral 1/2 length bed rails on the resident's bed.

On 1/6/14 at approximately 3:00 P.M. nursing administrative staff E stated the facility placed the 1/2 length side rails between 1/2/14 and 1/6/14 per the resident's family request. Nursing administrative staff E stated the resident used a hand rail/mobility bar prior to the placement of the side rail. Nursing administrative staff E stated the facility implemented the PBA after the resident's fall on 1/1/14. Nursing administrative staff E confirmed the resident's care plan did not include side rails.

On 1/6/14 at approximately 4:40 P.M. direct care staff P stated the resident was at risk for falls, and staff visually checked on the resident every 15 to 20 minutes. Direct care staff P stated the

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facility implemented the PBA, side rail and the winged mattress after the resident's fall on 1/1/14.

On 1/8/14 at 2:43 P.M. licensed staff H stated staff checked on the resident every 15 to 30 minutes, and the resident did not have a history of falling out of bed. Licensed staff H stated the facility implemented the PBA after the resident fell on 1/1/14.

On 1/8/14 at 3:00 P.M. nursing administrative staff D stated the resident had never fallen out of bed. Nursing administrative staff D stated the resident was use to sleeping in a larger bed and when the resident rolled/turned over he/she was probably attempting to reach the hand bar and rolled out of bed on 1/1/14.

The facility's fall prevention program revised 9/28/10 included residents who sustained a fall would have fall interventions implemented by the charge nurse on the day of the fall. The Director of Nursing or MDS Coordinator reviewed all falls and vitals. Further interventions would be added as needed.

The facility failed to implement effective and timely interventions for this cognitively impaired dependent resident with a history of falls who fell and sustained a hematoma, and vertebral fracture after falling/rolling out of bed on 1/1/14.

- Resident #47's significant change Minimum Data Set (MDS) 3.0 dated 12/4/13 identified the resident scored 8 (moderately impaired cognition) on the Brief Interview for Mental Status, had verbal behaviors 1 to 3 days of the 7 day look back period, was independent with bed mobility, required staff supervision with transfers, walking in the room, required limited staff assistance

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with walking in the corridor, and locomotion on/off the unit, and required extensive staff assistance with dressing, toilet use and personal hygiene. The MDS coded the resident was not steady but able to stabilize without staff assistance when walking, turning around and facing the opposite direction and surface to surface transfers. The MDS coded the resident was steady when moved from seated to standing and moving on/off the toilet, did not use mobility devices, and was occasionally incontinent of urine. The MDS included the resident had not fallen since the prior assessment and did not receive antipsychotic medications.

The resident's Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 12/5/13 included the resident had impaired cognition and staff cued and reminded him/her regarding all activities of daily living (ADLs). The resident had short and long term memory impairment and forgot to use his/her call light.

The resident's ADL CAA dated 12/5/13 documented the resident was ambulatory, had impaired vision, and the staff cued and assisted the resident with ADLs. The resident sometimes had problems with his/her balance and used a walker.

The resident's Fall CAA dated 12/5/13 documented the resident was a fall risk, had a history of falls with and without injury. The resident's balance problems fluctuated depending upon the day. The resident utilized a walker, and staff accompanied him/her with long distances due to the resident's history of past falls. The resident sometimes forgot to use his/her walker,

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the resident safely transferred from his/her recliner, and the Certified Nurse Aides frequently checked him/her.

The resident's care plan had the following interventions in place since 6/18/13: The resident needed staff assistance to complete his/her ADLs, the resident had dementia, was at risk for falls and ambulated with a walker. The resident needed staff to walk him/her to the dining room table, the resident forgot to use his/her call light, and staff frequently checked on the resident during rounds and when they passed the resident's room. The resident required standby assist of 1 staff when ambulating outside of his/her room. The resident tended to run into things with his/her walker, and veered off to the right with it. An entry dated 12/11/13 documented staff assisted the resident out of the room where he/she could be viewed easier and the resident continued with the positioning bar. An entry dated 12/19/13 included the resident required stand by assist when he/she ambulated with the walker and the resident could use the wheelchair for long distances and if fatigued. An entry dated 1/6/14 included staff checked the resident for orthostatic hypotension (drop in blood pressure when positions changed), 1 staff assisted the resident with transfers, and the resident may use the wheelchair. The resident fall risk increased when he/she was in his/her room and staff brought the resident out of his/her room after dressing for easier view. Staff frequently checked on the resident, at night very frequently when passing his/her room if awake, one staff assisted him/her with all transfers, and staff did not leave the resident unattended.

A nurse's note dated 5/22/2013 and timed 6:59 A.M. documented at 5:15 A.M. the resident put on

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his/her call light, the resident was on the floor in his/her bathroom beside the toilet. The resident had a cut on his/her right eye brow.

A nurse's note dated 12/4/2013 and timed 5:48 P.M. documented the resident returned from a physician's appointment with a new order to start Zyprexa (an antipsychotic) 2.5 milligrams(mg) everyday.

A nurse's note dated 12/7/2013 and timed 1:45 P.M. documented the resident laid on his/her left side, the resident's head was on the floor and staff observed a small amount of blood on the resident's nose and cheek. The resident complained of pain to his/her nose, bruising and a small laceration was noted at the top of the resident nose. The resident stated he/she rolled out of bed. Interventions included staff frequently checked on the resident, staff left the resident's room door open, staff positioned the resident in the middle of the bed, and placed a mattress on the floor next to the resident's bed.

A nurse's note dated 12/9/2013 and timed 3:34 A.M. documented at 12:20 A.M. staff observed the resident sitting on the floor beside his/her mattress on the floor scooting himself/ herself along. Intervention included staff frequently checked on the resident and offered toileting to the resident before/after meals, before going to bed, and upon awakening.

A nurse's note dated 12/11/2013 and timed 2:40 P.M. documented the resident was in a common bathroom, turned on the call light, staff went to check on the resident and the resident was sitting on the floor in front of the toilet. The resident stated he/she hit his/her head on the toilet. The fall review sheet did not include an intervention.

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F 323	Continued From page 29 A nurse's note dated 12/23/2013 and timed 8:46 P.M. documented the facility received a physician's order to increase the resident's Zyprexa to 2.5 mg twice a day for 10 days. A nurse's note dated 1/6/2014 and timed 2:38 A.M. included at about 2:20 A.M. staff found the resident next to his/her bed, and the resident's back was against the bedside cabinet. The resident stated he/she stood up, could not remain standing, so he/she sat down on the floor. A nurse's note dated 1/7/2014 timed 3:30 P.M. documented at 1:30 P.M. the resident was down by the dining room doors, stood up out of his/her wheelchair and ambulated. The resident tripped over his/her own feet on the way back to the wheelchair and hit the back of his/her head on the door frame between the two doors. Staff applied an ice pack to the back of the resident's head. On 1/2/14 at approximately 12:15 P.M. the resident sat in his/her wheelchair at a dining room table. On 1/6/14 at 8:45 A.M. the resident self propelled his/her wheelchair in the hallway. On 1/6/14 at 1:10 P.M. (1) staff transferred the resident from his/her wheelchair to a recliner in the television room. On 1/7/14 at 6:55 A.M. the resident laid in bed. Observation revealed the resident had a hand rail/positioning bar on the left side of his/her bed. Further observation revealed the resident's bed approximately 5 inches from the ground. The observation revealed 3 non skid strips by his/her bed.	F 323		

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F 323	Continued From page 30 On 1/7/14 at 4:35 P.M. direct care staff P stated staff placed a thin mat beside the resident's bed when the resident was in bed, the resident's bed was 5 or more inches from the ground and the resident had a positioning bar on his/her bed. On 1/8/14 at 2:53 P.M. licensed nurse H stated staff checked on the resident every 15 to 30 minutes. The resident was at risk for falls, fell on 1/7/14 and did not utilize a mat on the floor. The resident had declined and now used the wheelchair most of the time. On 1/8/14 at approximately 3:40 P.M. nursing administrative staff D stated the resident was at risk for falls and staff frequently checked on the resident. Administrative nursing staff D stated the resident started on Zyprexa during the middle of December and the facility had not reviewed/accessed the resident to see if there was a possible correlation between the resident's increase in falls and the start of the Zyprexa. The facility's fall prevention program revised 9/28/10 included residents who sustained a fall would have fall interventions implemented by the charge nurse on the day of the fall. The Director of Nursing or MDS Coordinator reviewed all falls and vitals. Further interventions would be added as needed. The facility failed to thoroughly assess and provide effective interventions for the prevention of falls for this cognitively impaired resident. - The January 2014 Physician's Order Sheet for resident #16 documented a diagnosis of	F 323		

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Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure).

The quarterly Minimum Data Set 3.0 (MDS) dated 7/9/13 noted a Brief Interview for Mental Status (BIMS) score of 11 (8 to 12 indicated moderately impaired cognition). It documented the resident required supervision for transfers, and was steady when moving from a seated to a standing position. It revealed the resident had not fallen.

The Care Area Assessment (CAA) dated 4/7/13 for cognition did not trigger.

The CAA dated 4/7/13 for falls indicated the resident was a fall risk and had declined in his/her walking endurance. He/she had a fall prior to an illness in March.

The care plan dated 7/10/13 noted staff left the call light within reach of the resident. Staff checked on the resident frequently and left the bathroom light on. Staff kept the pathway to the bathroom free from clutter, including the wheelchair. Staff used one on one conversation and anticipated the resident's needs. It noted the resident was reluctant to call for help.

A fall risk assessment dated 7/8/13 noted a score of 17 (10 or above indicated a high risk for falls).

The nurse's notes dated 3/26/13 at 11:30 A.M. documented the resident fell in his/her room while making his/her bed. The clinical record lacked documentation of new interventions or evaluation of the current interventions.

The nurse's notes dated 8/29/13 at 3:36 P.M. documented there were no complaints of

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discomfort from the fall "yesterday'. The nurse's notes lacked further documentation about a fall on 8/28/13, any new interventions, or evaluation of the current interventions.

The nurse's notes dated 9/30/13 at 6:29 P.M. revealed staff found the resident on the floor, and was transported to the emergency room. The x-ray report dated 9/30/13 noted there was a fracture of the right hip. The fall investigation noted staff were to keep the resident's door open and pull the divider curtain. Staff failed to place these interventions on the care plan.

The nurse's notes dated 10/11/13 at 10:09 A.M. documented the resident was observed sitting on the floor in the TV room. The fall investigation noted staff were to keep the resident within the line of sight, to keep the light on in the TV room, and to keep the TV on a channel the resident prefers. Staff failed to place these interventions on the care plan.

The nurse's notes dated 10/15/13 at 8:31 P.M. documented the direct care staff found the resident in the TV room on his/her back laying on the floor. The fall investigation noted staff were to toilet the resident often and visit with the resident when he/she was anxious. These interventions failed to be placed on the care plan.

The nurse's notes dated 10/29/13 at 3:15 P.M. documented the resident fell in his/her room while making his/her bed. The fall investigation noted staff were to make the resident's bed, and this was added to the care plan.

A nurse's note dated 11/2/13 timed 8:38 P.M. documented the resident made poor judgements and attempted to climb over the foot rest of the

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recliner.

The nurse's notes dated 11/9/13 at 9:25 P.M. documented the resident was found sitting on the floor. A fall investigation was not provided for this date.

A nurse's noted dated 11/15/13 timed 8:12 P.M. documented the resident's gait was unsteady at times and used unsafe ambulation, such as not using the walker, ambulating with one shoe on and only a sock on the other foot.

The nurse's note dated 11/21/13 at 2:05 P.M. documented the resident was in the TV room, went to sit in his/her wheelchair, the chair wheeled backwards, and he/she sat on the floor. The fall investigation noted staff needed to know where the resident was. This interventions failed to be placed on the care plan.

The nurse's note dated 11/25/13 at 3:47 P.M. documented the resident was observed sitting on the floor in the great room. The fall investigation noted to involve the resident in more activities. This was added to the care plan.

The nurse's note dated 11/26/13 at 6:15 A.M. documented staff found the resident laying on the floor in his/her room. The fall investigation noted the night shift staff were to check on the resident more frequently at night. This was added to the care plan.

The nurse's note dated 11/30/13 at 1:16 P.M. documented the resident was found laying next to the recliner with his/her head against the wall. The fall investigation lacked documentation of new interventions or evaluation of the current interventions.

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The nurse's note dated 12/2/13 at 1:03 P.M. documented the resident was observed sitting in the hallway up against the director of nursing's door. The fall investigation lacked documentation of new interventions or evaluation of the current interventions.

The fall investigation dated 12/4/13 documented a fall. The nurse's notes lacked documentation about a fall on 12/4/13. The fall investigation lacked documentation of new interventions or evaluation of the current interventions.

The fall investigation dated 12/5/13 documented a fall. The nurse's notes lacked documentation about a fall on 12/5/13. The fall investigation lacked documentation of new interventions or evaluation of the current interventions.

The nurse's notes dated 12/21/13 at 3:03 A.M. the resident was observed by staff laying on the floor in the hall outside of his/her room. The fall investigation lacked documentation of new interventions or evaluation of the current interventions.

Observation on 1/6/13 at 2:30 P.M. the resident sat in a recliner with the foot rest elevated. He/she scooted out to the edge of the foot rest. The resident attempted several times to stand up, and eventually succeeded. He/she sat back down before staff noticed he/she was standing. The resident continued to try to stand back up. A nurse sat at the nurse's station nearby. When staff noticed the resident trying to stand up, staff transferred the resident to a wheelchair.

Interview on 1/7/13 at 4:40 P.M. direct care staff P stated the resident was a fall risk. He/she made

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F 323	Continued From page 35 a point to check on the resident at every chance in order to prevent further falls, he/she checked on the resident frequently, assisted the resident around the facility, and ensured his/her needs were met. Interview on 1/8/14 at 1:15 P.M. licensed nursing staff I stated the resident was a fall risk, and staff should check him/her every 15 minutes. Interview on 1/8/13 at 2:50 P.M. licensed nursing staff H stated the frequent checks were not documented. Interview on 1/8/14 at 3:40 P.M. administrative nursing staff D stated this resident was a fall risk. Staff had evaluated this resident's medications and monitored for behaviors to prevent further falls. Staff were to use redirection and keep within sight. Staff were expected to check on the resident at every opportunity. On 1/9/13 at 2:30 P.M. physician KK was unavailable for interview. The facility's policy "Fall Prevention Program", dated 9/28/10, noted possible contributing factors were explored after each fall. The facility failed to implement effective interventions for this cognitively impaired resident who fell and fractured his/her hip and continued to fall.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This Requirement is not met as evidenced by:
The facility identified a census of 50 residents. The sample was 19 residents, 5 of which were reviewed for medications. Based on observation, record review and interview, the facility failed to consistently monitor bowel movements and blood pressures for resident (#33), and failed to list targeted behaviors to specific medications for resident (#16).

Findings included:

- Resident #33's medical diagnosis listed on the electronic chart revision dated 11-1-2013 were constipation and hypertension (elevated blood pressure).

The 12-25-2013 quarterly Minimum Data Set

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documented the Brief Interview of Mental Status score of 10 which indicated moderately impaired cognition.

The physician's orders listed in the electronic chart dated 11-3-2013 documented on: 5-7-2013 multivitamin tablet chewable give 1 tablet by mouth one time a day for dietary supplement. Dated 5-7-2013 milk of magnesia suspension 400 milligrams/5 milliters give 1 dose by mouth two times a day related to constipation. Dated 5-7-2013 Bisacodyl 5 milligrams (mg) as needed related to constipation. Dated 5-7-2013 Nebivolol HCl tablet 5 milligrams give 1 tablet by mouth one time a day related to Hypertension.

The 11/13 Activities of Daily Living flow sheet from 11/9/13 to 11/12/13 (4 days) lacked documentation of a bowel movement for this resident.

The blood pressure summary in the electronic chart displayed the following blood pressures:
12-20-2013 at 6:04 A.M. 188/74 resident lying position left arm manually
12-2-2013 at 6:12 A.M. 188/81 resident lying position left arm manually
11-29-2013 at 6:12 A.M. 187/74 resident lying position left arm manually
11-17-2013 at 6:53 A.M. 191/75 resident lying position left arm manually
10-4-2013 8:11 A.M. 189/80 resident lying position left arm manually
9-28-2013 7:07 P.M. 195/74 resident standing position left arm manually
9-10-2013 8:07 A.M. 188/83 resident lying position right arm manually

Observation on 1-2-2013 at 11:54 A.M. revealed the resident sat in his/her wheelchair in the dining

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F 329	Continued From page 38 room and visited with dietary staff. Interview on 1-7-13 at 3:06 P.M. with direct care staff O revealed the Certified Nursing Assistants were responsible for recording bowel movements. Staff had a book to chart the bowel movements in. The day shift CNAs take vital signs as assigned. Interview on 1-8-2013 at 12:25 P.M. with licensed nursing staff H revealed if the blood pressure protocol was 200 Millimeters of Mercury or over for the systolic blood pressure, nursing staff would call the doctor per the standing orders. The CNA staff were responsible for recording bowel movements in the Activities of Daily Living book. If a resident went 2 days without a bowel movement nursing staff gave Bisocodyl, and if no bowel movement in 8 hours nursing staff gave milk of magnesia, 8 hours later without a bowel movement nursing staff gave a suppository. He/she acknowledged there was lack of documentation for bowel movement for dates 11-9-13 to 11-12-13, and no intervention for lack of bowel movement was charted. Interview on 1-8-13 at 3:06 P.M. with administrative nursing staff D revealed nursing staff had standing orders for all residents in the facility. If the systolic blood pressure was over 200 nursing staff reported it to the doctor. If the systolic was under 200 we do not report to the doctor. The bowel movement protocol starts at the end of day 2. If there was no bowel movement nursing staff gave a bisacodyl suppository. If no bowel movement in 8 hours nursing staff gave milk of magnesia, if no bowel movement in 8 hours nursing staff give bisacodyl by mouth. If no bowel movement in 8 hours nursing staff gave an enema. Some people just	F 329		

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do not go regularly. The nurses should assess the abdomen and bowel sounds. The CNAs were responsible for documenting bowel movements. I expected the nurse to assess the resident and started the constipation protocol.

The facility provided 5-19-10 vital sign protocol revealed the physician shall be notified if the blood pressure systolic was 100 or below, or 180 or above. The policy for initiation of standing orders for constipation, undated, revealed the standing orders were: at the end of day 2 with no bowel movement give Bisacodyl suppository, rectally or 1 tab by mouth, if no bowel movement in 8 hours give Milk of Magnesia, 15-30 cubic centimeters, by mouth, if no results in 8 hours give 2 tablets Bisacodyl by mouth, if no results within 8 hours give an enema, not to exceed two consecutive days without results. Results shall be documented on the medication administration record and in the shift report book.

The facility failed to to consistently monitor bowel movements and monitor for the effectiveness of the Nebivolol.

- The January 2014 Physician's Order Sheet for resident #16 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) and psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing). It noted the resident received Ativan as needed (a medication to help with anxiety) and Seroquel (a medication to treat a psychotic disorder).

The Significant Change Minimum Data Set 3.0

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(MDS) dated 11/26/13 noted a Brief Interview for Mental Status (BIMS) score of 9 (8 to 12 indicated moderately impaired cognition). It documented the resident had physical behavioral symptoms directed toward others.

The Care Area Assessment (CAA) dated 11/26/13 for cognition noted the resident continued to have confusion.

The CAA dated 11/26/13 for behavioral symptoms noted the resident did well with one person cueing and a quiet environment seemed calming.

The care plan dated 10/11/13 noted the resident did best with one on one conversations. Staff anticipated the resident's needs if the resident was not answering questions. Staff reassured the resident, spoke calmly, and smiled at him/her.

Behavior monitoring documentation for October 2013, November 2013, and December 2013 noted to document if the resident exhibited signs or symptoms of deviation from his/her normal state. It failed to indicate specific behaviors for the resident as they related to the Ativan and Seroquel.

Observation on 12/31/13 at 3:15 P.M. the resident appeared to sleep in the recliner, and appeared calm with no behavioral symptoms noted.

Observation on 1/6/14 at 9:30 A.M. the resident listened to a group discussion, and appeared calm with no behavioral symptoms noted.

Interview on 1/7/14 at 4:40 P.M. direct care staff P stated the resident became fidgety when

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F 329	Continued From page 41 anxious. Interview on 1/8/14 at 1:15 P.M. licensed nursing staff I stated the resident had anxiety at times and would become fidgety. Interview on 1/8/14 at 3:10 P.M. administrative nursing staff D confirmed the resident's behavior monitoring was not specific to the medications the resident received. The facility policy "Behavior Monitoring Policy", undated, noted "behaviors were to be tied to a diagnosis and targeted behaviors". The facility failed to monitor for the effectiveness of the medications this cognitively impaired resident received.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility identified a census of 50 residents served from one main kitchen. Based on observation and interview, the facility failed to properly handle and store dishes, store opened food, and handle food in a sanitary manner. Findings included:	F 371		

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F 371	Continued From page 42 - During the initial kitchen tour on 12/30/13 at 10:00 A.M. the following were noted: mixing bowls were stored uncovered right side up opened, undated sliced cheese, vegetables and canned fruit in the refrigerator in the kitchen small bowls stored uncovered right side up in the serving area opened, undated bag of uncooked hamburger patties in the freezer Observation on 12/30/13 at 11:30 A.M. dietary staff handled glasses around the rim with bare hands. Observation on 1/6/14 at 12:00 P.M. dietary staff wore gloves, opened the hamburger bun sack, removed a bun, and placed it on a plate. Interview on 1/8/14 at 2:00 P.M. dietary staff DD stated staff should date opened food items in the refrigerators. Staff should handle glasses in a sanitary manner and change the gloves when they became soiled. He/she acknowledged the mixing bowls and serving bowls were stored uncovered and right side up. The facility failed to provide a policy about food storage or safe food handling. The facility failed to prepare, store, and distribute food in a sanitary manner.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 43 the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility identified a census of 50 residents. The sample was 19 residents, 5 of which were reviewed for medications. Based on observation, record review and interview, the facility failed to consistently monitor bowel movements and blood pressures for resident (#33), and failed to list targeted behaviors to specific medications for resident (#16). Findings included: - Resident #33's medical diagnosis listed on the electronic chart revision dated 11-1-2013 were constipation and hypertension (elevated blood pressure). The 12-25-2013 quarterly Minimum Data Set documented the Brief Interview of Mental Status score of 10 which indicated moderately impaired cognition. The physician's orders listed in the electronic chart dated 11-3-2013 documented on: 5-7-2013 multivitamin tablet chewable give 1 tablet by mouth one time a day for dietary supplement. Dated 5-7-2013 milk of magnesia suspension 400 milligrams/5 milliners give 1 dose by mouth two times a day related to constipation. Dated 5-7-2013 Bisacodyl 5 milligrams (mg) as needed related to constipation. Dated 5-7-2013 Nebivolol HCl tablet 5 milligrams give 1 tablet by mouth one time a day related to Hypertension.	F 428		

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The monthly medication regimen reviews from 4-4-13 to 12-10-13 no concerns. Pharmacist consult note to attending physician/prescriber dated 1-3-14, 10-22-13, and 9-25-13 noted no concerns.

The 11/13 Activities of Daily Living flow sheet from 11/9/13 to 11/12/13 (4 days) lacked documentation of a bowel movement for this resident.

The blood pressure summary in the electronic chart displayed the following blood pressures:
12-20-2013 at 6:04 A.M. 188/74 resident lying position left arm manually
12-2-2013 at 6:12 A.M. 188/81 resident lying position left arm manually
11-29-2013 at 6:12 A.M. 187/74 resident lying position left arm manually
11-17-2013 at 6:53 A.M. 191/75 resident lying position left arm manually
10-4-2013 8:11 A.M. 189/80 resident lying position left arm manually
9-28-2013 7:07 P.M. 195/74 resident standing position left arm manually
9-10-2013 8:07 A.M. 188/83 resident lying position right arm manually

Observation on 1-2-2013 at 11:54 A.M. revealed the resident sat in his/her wheelchair in the dining room and visited with dietary staff.

Interview on 1-7-13 at 3:06 P.M. with direct care staff O revealed the (CNA) Certified Nursing Assistants were responsible for recording bowel movements. Staff had a book to chart the bowel movements in. The day shift CNAs take vital signs as assigned.

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Interview on 1-8-2013 at 12:25 P.M. with licensed nursing staff H revealed if the blood pressure protocol was 200 Millimeters of Mercury or over for the systolic blood pressure, nursing staff would call the doctor per the standing orders. The CNA staff were responsible for recording bowel movements in the Activities of Daily Living book. If a resident went 2 days without a bowel movement nursing staff gave Bisocodyl, and after 8 hours later without a bowel movement nursing staff gave milk of magnesia, 8 hours later without a bowel movement nursing staff gave a suppository. He/she acknowledged there was lack of documentation for bowel movement for dates 11-9-13 to 11-12-13, and no intervention for lack of bowel movement was charted.

Interview on 1-8-13 at 3:06 P.M. with administrative nursing staff D revealed nursing staff had standing orders for all residents in the facility. If the systolic blood pressure was over 200 nursing staff reported to the doctor. If the systolic was under 200 we do not report to the doctor. The bowel movement protocol starts at the end of day 2. If there was no bowel movement nursing staff gave a bisacodyl suppository. If no bowel movement in 8 hours nursing staff gave milk of magnesia, if no bowel movement in 8 hours nursing staff give bisacodyl by mouth. If no bowel movement in 8 hours nursing staff give an enema. Some people just do not go regularly. The nurses should assess the abdomen and bowel sounds.

Attempted Interview with consultant pharmacist JJ via telephone on 1-9-2014 was unsuccessful.

The facility provided 5-19-10 vital sign protocol revealed the physician shall be notified if the blood pressure systolic was 100 or below, or 180

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F 428	Continued From page 46	F 428		

or above. The policy for initiation of standing orders for constipation, undated, revealed the standing orders: at the end of day 2 with no bowel movement give Bisacodyl suppository, rectally or 1 tab by mouth, if no bowel movement in 8 hours give Milk of Magnesia, 15-30 cubic centimeters by mouth, if no results in 8 hours give 2 tablets Bisacodyl by mouth, if no results within 8 hours give an enema, not to exceed two consecutive days without results. Results shall be documented on the medication administration record and in the shift report book.

The consultant pharmacist failed to identify the medication irregularities.
- The January 2014 Physician's Order Sheet for resident #16 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) and psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing). It noted the resident received Ativan as needed (a medication to help with anxiety) and Seroquel (a medication to treat a psychotic disorder).

The Significant Change Minimum Data Set 3.0 (MDS) dated 11/26/13 noted a Brief Interview for Mental Status (BIMS) score of 9 (8 to 12 indicated moderately impaired cognition). It documented the resident had physical behavioral symptoms directed toward others.

The Care Area Assessment (CAA) dated 11/26/13 for cognition noted the resident continued to have confusion.

The CAA dated 11/26/13 for behavioral symptoms noted the resident did well with one person cueing and a quiet environment seemed

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calming.

The care plan dated 10/11/13 noted the resident did best with one on one conversations. Staff anticipated the resident's needs if the resident was not answering questions. Staff reassured the resident, spoke calmly, and smiled at him/her.

Behavior monitoring documentation for October 2013, November 2013, and December 2013 noted to document if the resident exhibited signs or symptoms of deviation from his/her normal state. It failed to indicate specific behaviors for the resident as they related to the Ativan and Seroquel.

The Medication Regimen Reviews dated 1/14/13, 2/11/13, 3/7/13, 4/5/13, 5/8/13, 6/10/13, 7/3/13, 8/9/13, 9/9/13, 10/13/13, 11/11/13, and 12/10/13 failed to acknowledge the need for specific behaviors for the resident as they related to the Ativan and Seroquel.

Observation on 12/31/13 at 3:15 P.M. the resident appeared to sleep in the recliner, and appeared calm with no behavioral symptoms noted.

Observation on 1/6/14 at 9:30 A.M. the resident listened to a group discussion, and appeared calm with no behavioral symptoms noted.

Interview on 1/7/14 at 4:40 P.M. direct care staff P stated the resident became fidgety when anxious.

Interview on 1/8/14 at 1:15 P.M. licensed nursing staff I stated the resident had anxiety at times and would become fidgety.

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F 428	Continued From page 48 Interview on 1/8/14 at 3:10 P.M. administrative nursing staff D confirmed the resident's behavior monitoring was not specific to the medications the resident received. On 1/9/14 pharmacy consultant JJ was unavailable for interview. The facility failed to provide a policy about pharmacy consultant services. The facility's pharmacy consultant failed to alert staff of the need to monitor for the effectiveness of the medications this cognitively impaired resident received.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 49 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 50 residents. Based upon observation and interview the facility failed to properly store an ice scoop to prevent cross contamination. Findings included: - On 1/6/14 at 10:05 A.M. observation revealed staff on the 100 hall with an ice bin. Further observation revealed staff entered a resident's room, exited the room with the resident's water pitcher, lifted the scoop from the ice bin, filled the pitcher with ice and then replaced the scoop back in the ice bin with the handle resting on the ice. After staff finished passing ice on the 100 hall the staff proceed to pass ice on the 300 hall and the same technique was observed. On 1/6/14 at 2:45 P.M. staff passed ice down the 100 hall. Observation revealed staff scooped ice with the scoop and then replaced the scoop in the bin. The handle of the scoop rested on the ice. On 1/8/14 at approximately 10:10 A.M. direct care	F 441		

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F 441	Continued From page 50 staff R passed ice on the 100 hall. Observation revealed the staff left the scoop in the ice bin. During interview with direct care staff R at that time, he/she stated the container where the scoop rested had broken some time ago; therefore the scoop remained in the ice bin. The facility failed to ensure cross containment when passing ice.	F 441		